Drug budgets and the strengthening of the PPRS

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In our series on the history of prescribing policy, Dr Darrin Baines traces how successive governments have attempted to curb drug costs. Here, he describes the introduction of drug budgets and the renegotiation of the PPRS.

KEY EVENTS

- 1991 Fundholding and indicative budgets introduced. For the first time since 1920 financial constraints were placed on GP prescribing
- 1993 Pharmaceutical Price Regulation Scheme (PPRS) renegotiated. More regulations were placed on the UK pharmaceutical industry in order to control their activities
- 1993 House of Commons investigation begun. Recommended changes to PPRS, but found no clear evidence on effects of fundholding scheme per se
- 1997 Office of Health Economics report published. Fundholding had a one-off budget effect, which led to short-term cost savings

Following the necessary legislation, medicines budgets were introduced in April 1991 under the auspices of the fundholding and indicative prescribing schemes.[1] Although the schemes were designed to control NHS drugs spends through better financial planning locally, the government did not feel confident enough to abolish the national Pharmaceutical Price Regulation Scheme (PPRS), which was renegotiated in October 1993.

Like its predecessor, the new round was designed to cover all branded products sold to the NHS (whether patented or not) and excluded over-the-counter (OTC) and generic drugs, private prescriptions (which could be partially or wholly excluded) and medicines on the Selected List.[2] As with all renegotiations since 1969, the scheme was based on profitability (rather than the prices of individual products), which was mainly assessed on a return of capital (RoC) basis. Under this arrangement, a capital-base was negotiated for each firm, upon which profits in the range of 17 to 21 per cent could be earned (if the company generated the necessary sales). For example, a company with an agreed capital-base of £100 million could make profits of between £17 and £21 million per year from the NHS.[3]

As the PPRS was primarily a profit control system, participating companies were free to set their own prices for new products and line extensions. Except in special circumstances, firms were not permitted to increase the prices of medicines already launched and were expected to reduce prices, restrict future increases and/or repay any excess revenues if their profits were above their RoC ceilings.

As a result, the prices of branded products prescribable in NHS general practice were, overall, determined by: the size of the capital-bases that PPRS companies secured and their ability to reach and stay within the RoC targets that they were set. Moreover, the regulations encouraged companies to launch drugs at higher prices because increases could not be made once the initial NHS price had been set.

As part of the 1993 settlement, the DoH secured a three-year 2.5 per cent reduction in the price of all products covered by the PPRS. Under the arrangement, participating firms could generate the required reduction by: reducing the price of all products in their portfolios by 2.5 per cent, modulating prices so that they changed at different rates, while ensuring that the specified target was met, and making a cash rebate instead of the agreed decrease. As a result of these measures, the government intended that between 1 October 1993 and 30 September 1996 the total cost of drugs that fundholding and non-fundholding practices could prescribe would be lower than otherwise would have been the case.

Health Committee investigation

In the month in which the new PPRS settlement was implemented, the House of Commons Health Committee began to take formal evidence for its investigation into: 'whether the measures introduced by the Government to control the NHS drugs budget are leading to more appropriate and cost-effective use of drugs in terms of current NHS resources and future patient needs'.[4] Although the committee received evidence on a whole range of related issues, at the heart of its investigation was the question of how the government could best promote patient welfare while containing costs, encouraging rational and effective prescribing and supporting a vigorous UK pharmaceutical industry.

During its investigation the Health Committee received evidence from a range of governmental and professional bodies (including the DoH and BMA) and examined many of the issues related to prescribing within the NHS. As part of the DoH's evidence the committee was informed that, in recent years, two-thirds of companies covered by the PPRS had exceeded the 21 per cent upper-limit on profits, while approximately 25 per cent of participants had been permitted to raise prices in order to reach their pre-agreed profit targets.

Although the DoH produced evidence specifically for its investigation, the Health Committee argued that the secrecy surrounding the operation of the PPRS made it very difficult to judge the overall effects of the scheme. As a result, the committee recommended that greater transparency should be introduced into the administration of the PPRS, in particular, by: publishing an annual report that listed the aggregate profits earned by each participating company, detailing the total value of all repayments made to the DoH as a result of excess profits, and specifying the sum of any price reductions made by the industry.

Another area of concern for the Health Committee was unintended effects that the PPRS could have had on the Government's attempts to encourage more cost-effective prescribing in NHS general practice. For example, the committee suggested that if GPs were persuaded to prescribe more drugs generically then PPRS companies could seek to increase their prices in order to reach their pre-agreed profit targets, which would serve to frustrate the government's aim of reducing the overall drugs budget. Indeed, any measure that affected the ability of participating companies to meet their profit targets were likely to result in requests for prices increases, which could affect attempts to control public expenditure on drugs. In consequence, the Health Committee argued that: 'This is a fundamental flaw in the PPRS which needs to be addressed in future arrangements'.

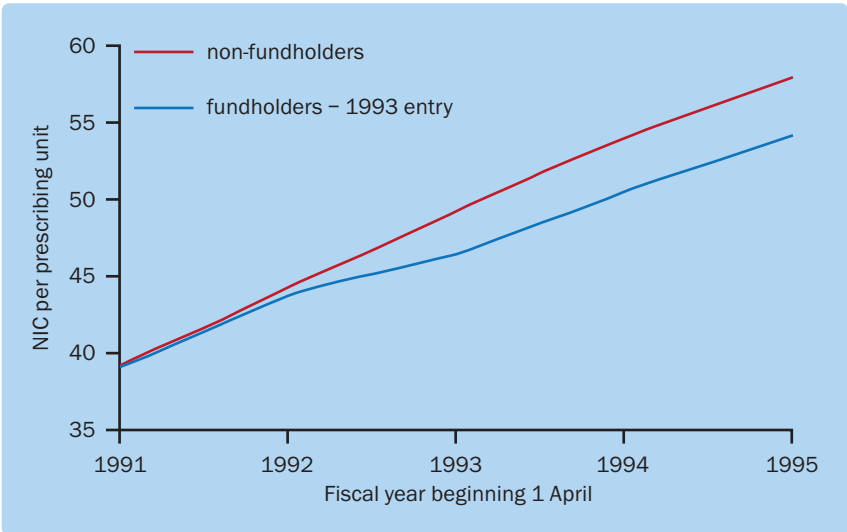

Figure 1. The 'budget effect' – savings made by practices entering the fundholding scheme in 1993 were not maintained in the longer term

Finally, the Health Committee received evidence from the Minister for Health on the operation of the fundholding and indicatives prescribing schemes. According to the minister, during fiscal 1992 all practices were allocated £57 per head for drugs, with fundholders spending £57 per patient and non-fundholders £61. During fiscal 1993, on the other hand, fundholders were allocated £62 per head and were projected to spend £61, while non-fundholders were allocated £64 and were expected to spend £68. Although the minister suggested that these differences could, in part, be explained by differential generic prescribing rates between the two groups, the committee received no evidence to suggest that patients of fundholding practices were receiving fewer of the medicines that they required because of the fundholding status of their GPs.

Although the Health Committee acknowledged that the fundholding scheme embodied several mechanisms designed to encourage more economic prescribing, its report suggested that additional factors may also have been at work. For example, at the time, the committee found that many fundholding practices were located in more affluent parts of the country where morbidity rates (and subsequently the need for more prescribed drugs) were lower. Moreover, evidence suggested that more highly-motivated doctors (who may have prescribed more economically even if they were not fundholders) may, initially, have been attracted to the scheme. However, in the absence of further evidence, the committee argued that 'how much weight one should give to those various explanations is a matter of opinion'.

Government response

In October 1994 the government published a response to the Health Committee's report on priority setting and the NHS Drugs Bill (DoH, 1994). As part of its reply, the government examined the committee's criticisms of the operation of the PPRS and the recommendation for the introduction of a National Prescribing List.

Under the first heading, the government argued that, because of commercial sensitivity, only a limited amount of information could be published about the

operation of the PPRS and that the scheme was not fundamentally flawed, as the profit levels of individual companies were not guaranteed.

In relation to the latter, the government argued that a National Prescribing List would not be advisable, particularly as it would not be easy or cheap to operate. Moreover, with the introduction of such initiatives as the fundholding and indicative prescribing schemes, the government was not convinced that such a list would produce substantial savings. Finally, as part of the government's response to the Health Committee's findings, the DoH agreed to produce an annual report on the PPRS; the first of which was published in May 1996.

The budget effect

In May 1997, New Labour won a landslide victory at the UK general election. In opposition, the party had been vehemently against the fundholding scheme. In power, the Government honoured its commitment to abolish the widely unpopular budgetary control mechanism. Just after the election, the Office of Health Economics published a review of the effect of the scheme. As Figure 1 from the report shows, the scheme had a 'budget effect'. In other words, practices made one-off savings when they first entered the scheme, but these were not sustainable in the longer term, as usual cost pressures encourage medicines spending upwards.

Further work by the same authors suggested that there may have been a 'selection bias' in the recruitment to the scheme.[6] As the Health Committee had hypothesised, practices attracted to the scheme in the early waves were characteristically different to those who joined later on or did not join the scheme at all. Against a background of equivocal evidence, practice drug budgets were not completely abolished by New Labour. Instead, the fundholding and indicative schemes were rebadged and reimplemented under the government's new plans for primary care groups (PCGs).

References

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In the next instalment of this series, Dr Baines will examine how prescribing policy evolved from the mid-1980s to late 1990s.